A 42 year old female was admitted with abdominal pain and fresh bleeding per rectum 2 days after a Delorme's procedure. CT thorax, abdomen and pelvis confirmed a large air/soft tissue collection in the pelvis with pneumoretroperitoneum, pneumomediastinum and subcutaneous emphysema. Emergency laparotomy, washout of the collection and formation of a defunctioning loop colostomy was carried out. Recovery was uneventful. She remains well on follow-up.

Air extrusion and sepsis in the absence of abdominal insufflation is explained by the presence of a rectal mucosal flap allowing air egress into the retroperitoneum, tracking along tissue planes into the thorax. This is followed by bacterial translocation across perirectal tissue. Emergency management includes fluid resuscitation, antibiotics, laparotomy with temporary or permanent faecal diversion via colostomy (60%), Hartmann's procedure (20%) or ileostomy (14%).

Surgeons need to be aware of pelvic sepsis with pneumoretroperitoneum as a rare complication of Delorme's procedure. Laparotomy and faecal diversion are indicated in the presence of peritonitis.

0914: TRAUMATIC RUPTURE OF THE STERNOCLEIDOMASTOID MUSCLE FOLLOWING AN EPILEPTIC SEIZURE

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A 29 year old known epileptic, presented to A&E following a tonic-clonic seizure lasting five minutes during which he fell striking his head. He suffered a second self-limiting seizure in the department. Following these he complained of neck pain, swelling and stiffness.

Otorhinolaryngology examination of his neck revealed: a tender left side with two palpable masses, reduced rotation to the right and lateral flexion to the left, and no focal neurological deficit.

Ultrasound scan showed a ruptured middle third of the left sternocleidomastoid muscle. He was treated non-surgically with analgesia and intensive physiotherapy. Six weeks later there was significant functional improvement despite a palpable defect in sternocleidomastoid.

Treatment of a ruptured sternocleidomastoid muscle is primarily conservative, with early physiotherapy aimed at reducing the torticollis risk and subsequent cosmetic and functional repercussions. Early surgical correction may be advocated in patients resistant to physiotherapy.

Sternocleidomastoid muscle rupture is an uncommon complication of high velocity trauma, but to our knowledge this is the first case described in the literature with epileptic seizure. The case illustrates the importance of thorough examination, to exclude significant pathology that may be masked by the presenting complaint, and effectiveness of conservative therapy in selected traumatic ruptures.

0932: A SINISTER CAUSE OF FACIAL PAIN: RHINO-ORBITO-CEREBRAL MUCORMYCOSIS

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Mucormycosis is an aggressive fungal infection which targets the immunocompromised and diabetics. Rhino-orbito-cerebral (ROC) mucormycosis is the most common presentation (44-49%) and often angioinvasive. We present a case of ROC mucormycosis.

A 44-year-old woman with poorly controlled Type 1 Diabetes presented with left sided facial pain. She was given Metronidazole for suspected dental abscess but returned one week later with sepsis and paralysis of left cranial nerves II-VII. MRI head diagnosed cavernous sinus thrombosis. CT showed infection in the maxilla, nasopharynx, left infratemporal fossa and the “black turbinate sign”. Meropenem and Vancomycin were started but were ineffective. She had functional endoscopic sinus debridement and biopsy, which diagnosed mucormycosis. Amphotericin B and Posaconazole were commenced. Repeat MRI revealed retrograde progression with brainstem involvement. She underwent further debridement of necrotic tissue. 9 days after presentation she became acutely unresponsive. CT head showed acute subarachnoid haemorrhage secondary to mycotic aneurysm, which proved fatal.

Mucormycosis is a rare but serious fungal infection, which must be suspected in at risk individuals. ROC mucormycosis carries a mortality rate between 30-69% and can cause intracranial haemorrhage. Aggressive surgical debridement, Amphotericin B and Posaconazole are required but despite these measures fatality is common.

1405: RESPIRATORY ARRESTS SECONDARY TO ACHALASIC MEGA-OESOPHAGUS: CASE REPORT AND LITERATURE REVIEW

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Primary achalasia is an uncommon oesophageal motility disorder, characterised by the failure of lower oesophageal sphincter to relax and aperistalsis. Commonest presenting symptoms include vague chest pain, dysphagia and aspiration. Severe airway compromise events are rare complications.

A 40-year-old man with achalasia was referred to our tertiary unit following two episodes of respiratory distress, secondary to tracheal compression by a megaoesophagus. A literature review was performed.

Initial presentation with stridor was resolved following pneumohydraulic dilatation. Achalasia was subsequently confirmed on manometry, endoscopy and contrast swallow. Three months later, he re-presented with cardiorespiratory arrest requiring intubation and defibrillation. Computed tomography revealed progressive mega-oesophagus filled with food debris causing tracheal compression. Endoscopic lavage was performed and nasogastric tube decompression was instituted.

Due to failure of endoscopic dilatation and the recurrence of respiratory distress, three-stage oesophagectomy was indicated for definitive management.

Partial airway obstruction secondary to achalasic mega-oesophagus was sporadically described in literature. Cardiorespiratory arrest presentation is rare. Pneumatic dilatation and cardiomyotomy remain the common treatments, and oesophagectomy tends to be reserved in refractory cases. A few case series reporting outcomes following oesophagectomy for achalasia have shown low mortality and complication rates with good functional recovery.

Collaborative research and audit protocols

0309: AN AUDIT CYCLE TO INVESTIGATE DISCHARGE ANALGESIA GIVEN TO DAY CASE SURGICAL PATIENTS BEFORE AND AFTER BRITISH ASSOCIATION OF DAY SURGERY GUIDELINE IMPLEMENTATION

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Introduction: The British Association of Day Surgery has clear guidelines for a stepwise approach to discharge analgesia for common day case procedures dependent on surgery type. It was perceived Ealing Hospital NHS Trust had no clear guidelines on appropriate discharge analgesia regimes for such patients. Consequently, a large number were discharged on strong opiates such as Tramadol inappropriately. Our aim was to identify all patients on potentially inappropriate regimes, then re-audit to assess compliance with guidelines.

Methods: A retrospective study of all day case surgical discharges over a three-month period. Their analgesia was noted against their procedure. We implemented changes in the form of teaching at local surgical and anaesthetic meetings and displayed guideline posters for reference. Re-audit of the subsequent three-month period showed significant service improvement.

Results: First audit (n=74) showed only 22% (n=16) receiving the correct analgesia and 34% (n=25) receiving Tramadol incorrectly. Repeat audit (n=87) showed 35% (n=30) receiving appropriate analgesia and only 17% (n=15) given Tramadol.

Conclusions: Many hospitals arbitrarily give strong opiates incorrectly to patients after simple day case procedures. We showed how auditing this, educating clinicians about current guidelines and their failure to implement them can lead to significant changes in prescribing.

0318: AN AUDIT OF TARGET TIME TO THEATRE FOR NON-ELECTIVE SURGERY ADMISSIONS

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Introduction: The National Confidential Enquiry into Patient Outcome and Death (CEPOD) has produced guideline target times for patients to undergo non-elective surgery based on their presentation. An audit was undertaken to assess whether CEPOD targets were achieved.